



IDAHO DEPARTMENT OF HEALTH & WELFARE

COPY

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

February 22, 2008

Louis Kraml, Administrator
Bingham Memorial Hospital
98 Poplar Street
Blackfoot, Idaho 83221

RE: Bingham Memorial Hospital, Provider #131325

Dear Mr. Kraml:

This is to advise you of the findings of the Medicare Validation survey of Bingham Memorial Hospital, which was done on February 13, 2008.

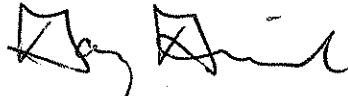
Enclosed are Statement of Deficiencies/Plan of Correction forms, HCFA-2567s, listing Medicare deficiencies. The hospital is under no obligation to provide a plan of correction for these deficiencies. If you do choose to submit a plan of correction, provide it in the spaces provided on the right side of each sheet. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.
2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
3. Identify the date each deficiency has been, or will be, corrected.
4. Sign and date the form(s) in the space provided at the bottom of the first page. Whether you choose to provide a plan of correction or not, please sign and date the form and return it to our office by **March 6, 2008**. Keep a copy for your records. For your information, the Statement of Deficiencies is disclosable to the public under the disclosure of survey information provisions.

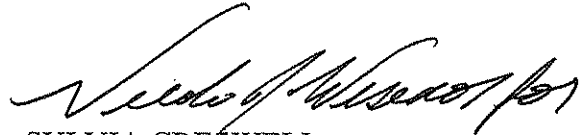
Louis Kraml
February 22, 2008
Page 2 of 2

Thank you for the courtesies extended to us during our visit. If you have any questions, please call (208)334-6626.

Sincerely,

Handwritten signature of Gary Guiles, consisting of a stylized 'G' followed by a series of loops and a final flourish.

GARY GUILLES
Health Facility Surveyor
Non-Long Term Care

Handwritten signature of Sylvia Creswell, featuring a large, elegant 'S' followed by a series of loops and a final flourish.

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/mlw

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131325	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2008
NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
C 000	INITIAL COMMENTS	C 000			
C 279	<p>The following deficiency was cited during the Medicare validation survey of your hospital. Surveyors conducting the validation were:</p> <p>Gary Guiles, RN, HFS, Team Leader Rae Jean McPhillips, RN, HFS</p> <p>485.635(a)(3)(vii) PATIENT CARE POLICIES</p> <p>[The policies include the following:]</p> <p>(vii) If the CAH furnishes inpatient services, procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patients, and that the requirement of §485.25(i) is met with respect to inpatients receiving posthospital SNF care.</p> <p>This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, it was determined the hospital failed to adopt procedures to ensure that the nutritional needs of inpatients were met. This affected 1 of 1 patient (Patient #1) with difficulty swallowing. The findings include:</p> <p>Patient #1 was an 81 year old male admitted to the hospital on 2/10/08 following a transient ischemic attack (mini-stroke). He was currently a patient as of 2/12/08. He had left sided weakness and difficulty swallowing. A swallow evaluation was completed on 2/11/08 at 11:10 AM. The corresponding speech therapy note recommended a mechanical soft diet. The dietician was interviewed on 12/12/08 at 10:30 AM. She stated she was aware the swallow</p>	C 279	<p>The CAH furnishes inpatient services, procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patients, and that the requirement of 485.25(i) is met with respect to inpatients receiving post hospital SNF care. The Standard is met as evidenced by:</p> <ol style="list-style-type: none"> 1. Policy and Procedure effective 3-1-2008, describing the process of immediate communication between Speech Pathology and the Hospital Dietician after swallow study completion. 2. Education completed to pertinent staff 2-27-2008. 3. Procedure is as follows: Speech Pathology staff will complete all swallow evaluations per protocol. If the results of the evaluation require a change in the patient's diet, the Speech Pathologist will notify the attending physician regarding the recommended diet change. The speech pathologist can then write the diet change as a verbal order in the patient record. The Speech Pathologist also notifies the dietician of the diet change. Finally, the dietician writes a summary report of the speech evaluation findings, recommendations, and actions in the progress notes section of the patient's record. 4. Evaluation of compliance with the above mentioned policy will be as follows: Evaluation of speech pathology recommendations and implementation will be incorporated as part of the nightly "Chart Check" process. The House Supervisors are designated responsibility and oversight of this process with random evaluations from Nursing Administration. 		

RECEIVED

MAR 07 2008

FACILITY STANDARD

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

CEO

3-5-08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution's safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BINGHAM MEMORIAL HOSPITAL

98 POPLAR STREET

BLACKFOOT, ID 83221

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 279	Continued From page 1 evaluation had been completed the previous day. She checked the patient's chart and spoke with the kitchen. She stated a mechanical soft diet had not yet been ordered and the dietary service was still providing regular texture meals. She stated no formal procedure was in place to ensure the dietician was notified of the results of swallow evaluations and the need to change diet orders to match patient needs.	C 279		

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B 000	16.03.14 Initial Comments No deficiencies were cited during the state licensure survey of your hospital. Surveyors conducting the review included: Gary Guiles, RN, HFS, Team Leader Rae Jean McPhillips, RN HFS	B 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">MAR 07 2008</p> <p style="text-align: center;">FACILITY STANDARDS</p>		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

YNZ511

If continuation sheet 1 of 1